P. Craig Silva Bar No. 6-3066
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Attorney for Defendant

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF WYOMING

JIMMIE G. BILES, JR., M.D., a resident of Wyoming,	)	
Plaintiff,	)	
vs.	)	No. 11CV-294-J
LISA SHAURETTE FALLON,	)	
Defendant.	)	

DEFENDANT'S MOTION FOR PROTECTIVE ORDER PURSUANT TO FED. R. CIV. P. 26(c) and 30(d)

COMES NOW Defendant, Lisa Shaurette Fallon, by and through Counsel P. Craig Silva, and moves for a protective order for the deposition of Ms. Fallon set for **November 17, 2011** in Indianapolis, Indiana. The grounds for this *Motion* are as follows:

1. A party seeking a protective order must show good cause and specific need for protection. *Landry v. Airlines Pilots Association*, 901 F.2d 404, 435 (5th Cir. 1990). "Good Cause exists when justice requires the protection of a party or person from any annoyance, embarrassment, oppression or undue burden or expense. *Fed. R. Civ. P.* 26(c). The Court must balance the competing interests of allowing the discovery and protecting the parties and deponents from undue burdens. *Farnsworth v. Procter & Gamble Co.*, 758 F.2d 1545, 1547 (11th Cir. 1985). Generally, it is within the discretion of the trial court to quash a discovery request due to a witness's failing health. *Fed. R.Civ. P.* 26(b)(2); *See also Ahrens v. Ford Motor Company*, 340 F.3d 1142, 1147 (10th Cir. 2003). It is important to note at the outset that this burden is higher if the witness is seeking to have the deposition prohibited entirely; in that case, the burden is one of showing extraordinary circumstances and is rarely granted. *Bucher v. Richardson Hospital Authority*, 160 F.R.D. 88, 92 (N.D. Tex. Dallas Div. 1994). Ms. Fallon is not seeking such extreme relief. She recognizes that she will have to be deposed in this case at some point, but simply wants her deposition postponed until after her surgery and the clearance of her doctor.

2. Factually, to this point, the parties have cooperated in discovery; for example, Ms. Fallon has answered numerous interrogatories posted to her and in a manner that was sooner than required by the Federal Rules of Civil Procedure. She

agreed to have her deposition done prior to the initial pretrial conference and any discovery order. Counsel for Ms. Fallon accepted service of a subpoena so that Ms. Fallon could get out of work for the deposition preparation and deposition which was to be held on 11/17/2011.

3. Ms. Fallon has sufficient "good cause." Ms. Fallon saw Dr. Kristina Box on **9/21/2011**. (Defendant's Ex. A). She was complaining of pelvic pain, dyspareunia (painful intercourse), and mixed urinary incontinence. *Id.* She seeks surgery but was not available for surgery until after the first of the year because of work. *Id.* On **10/12/2011, she** sees Dr. Tetrick. (Defendant's Ex. B). She has pelvic pain, dysmenorrheal (pain during menstruation that interferes with daily activity). *Id.* She complains of being in pain the entire month. *Id.* The urinary incontinence continues. *Id.* She then sees Dr. Tetrick on **11/08/2011.** On **11/5/2011**, she was lifting a patient at work and felt something internally pop. (Defendant's Ex. C). She is diagnosed 2nd degree cysteocele (wall between bladder and vagina weaken causing bladder to droop into vagina) and prolapsed uterus. *Id.* She is fitted with a pessary device (device placed in vagina to hold the bladder in place). Because of these serious medical conditions, one of her doctors has opined that she should maintain bed rest and should not participate in any deposition until after her recovery from surgery. (Letter Dr. Ex. D). This is why her surgery date has been moved up from 2012 to December, 2011.

4. This is sufficient good cause for postponement of the deposition until after her recovery. There are numerous cases supportive of this view; for example, the Tenth Circuit Court of Appeals in *Mary Ahrens v. Ford Motor Company*, 340 F.3d 1142 (10th Cir. 2003) affirmed the trial court when it prohibited completely the deposition of two employees because of their health issues and age. The general rule is that if an oral deposition will pose a threat to a witness's health, the court will exercise its discretion in favor of a protective order. This was the rule in *United States v. Mariani*, 178 F.R.D. 447 (M.D. Penn. 1998). In that case, the witness, Louis Serafini, contended that as a result of his weakened physical condition a deposition would threaten his life. *Id.* at 449. The witness was 83 and suffered from myocardial infarctions, coronary artery disease and had been in and out of the hospital. *Id.* The witness was ultimately confined to his home where he received daily medical care. *Id.* His doctor testified at hearing on the motion for deposition that the stress of a deposition would or could trigger an irreversible cataclysm reaction that would cost Lois Serafini his life. *Id.* The Court went on to prohibit that deposition all together. *Id.* at 451.

5. A similar result was reached in *Dr. G. Ray Motsinger v. Flynt*, 119 F.R.D. 373 (M.D. NC. 1988), wherein the Court held:

> A doctor's certificate setting out plaintiff's illness and the basis for requesting exemption from a deposition will often justify a short stay in taking the deposition. . .

Id. In *Motsinger*, it was held that usually the plaintiff has to come forward with detailed information supporting the opinion and, if necessary, be willing to submit his physician for examination by the court or by defendant on behalf of the court. *Id.* In *Motsinger*, plaintiff had a congestive heart condition and the deposition was stayed. *Id* at 378. Likewise in, *Medlin v. Andrew*, 113 F.R.D. 650 (M.D. NC. 1987), plaintiff moved for a protective order which was granted preventing the deposition of plaintiff. Plaintiff submitted a letter from her psychiatrist which briefly states that plaintiff has been showing progressive deterioration in her mental state and is anxious and disorganized and in his opinion plaintiff should not be deposed without presenting risk of further deterioration. *Id.* at 652. Based on those facts, the court granted a limited stay of the deposition.

6. Ms. Fallon's need is not any less impressive than those outlined above. She has a serious medical condition for which her medical provider has explained that she is in no condition to give a deposition. As such, she seeks from this Court an Order not precluding her deposition entirely but instead to postpone it until she has the necessary surgery and recovery time so that she can properly attend and participate in her deposition.

7. Pursuant to U.S.D.C.L.R. 37.2(a), "Motion to Quash Deposition Notice and Motion for Protective Order Pending resolution of any motion under Fed. R. Civ. P.

26(c), 30(d), or 45(c), neither the objecting party, witness nor any attorney is required to appear at the deposition to which a motion to quash is directed until the motion is ruled upon. The filing of a motion under any of these Rules shall stay the discovery to which the motion is directed pending further order of the Court. . ."

8. Pursuant to Fed. R. Civ. P. 26(c) and U.S.D.C.L.R. 37.1, Defendant certifies that through counsel she communicated orally with the Plaintiff's counsel in an effort in good faith to resolve the dispute.

WHEREFORE, Defendant requests the Court to postpone her deposition until after she has recovered from her surgery.

Dated this 11th day of November, 2011.

/s/ P. Craig Silva
P. Craig Silva, Bar #6-3066
Williams, Porter, Day & Neville, P.C.
P. O. Box 10700
Casper, WY 82602
307.265.0700

CERTIFICATE OF SERVICE

I hereby certify that on November 11, 2011, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will send e-mail notification of such filing to the following: M. Kristeen Hand, R. Daniel Fleck and William L. Simpson.

/s/ P. Craig Silva
P. Craig Silva

Clearvista Women's Care
7120 Clearvista Drive Suite 4000 Indianapolis, IN 46256
317-621-7444 Fax: 317-621-3150

Lisa Shaurette
Female DOB [redacted] 1360
Ins: Prohealt (433) Grp: CHM001

09/21/2011 - GYN Office Visit: Discuss Pelvic US,pelvic pain,dyspareunia,mixed urinary incont
Provider: Kristina Box, MD
Location of Care: Clearvista Women's Care

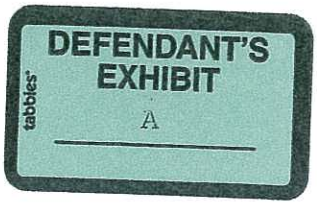
PCP: Dr David Tetrick
HPI: G4P4 SVD x4 largest 7#9oz
Pelvic pain,dysmenorrhea, deep dyspareunia, mixed urinary incontinence.
Lisa is tired of being in pain all month. Her pain is crampy, suprapubic pressure. Intercourse causes stabbing pain so she avoids having sex. This is causing some marital problems.
Menses are every 21 -25 days apart,lasitng 6 days. She has one day of spotting before her period. Cramping for 2 days, 800 mg Ibuprofen bid takes the edge off.
BMs are very painful during her menses. Constipation has become a problem. Normal colonoscopy with Dr Carlson.
Symptoms of mixed urinary incontinence. She wears a panty liner most days. She does not feel like she empties out when she voids. She has had two hospitalizations for pyeolnephritis. She does have a history of renal stones.
Recent labs show an elevated TSH=5.76 FT4=1.3 FSH=7.6 E2=47.1 Prolactin=18.6. She has not made an appt with a PCP for her thyroid. She has to change physicians due to insurance.
She sees Dr Kim soon for evaluation of a left breast mass.
Lisa very much desires permanent surgery for her pelvic pain. She would also like to fix her stress incontinence. She is not be able to do surgery until after the first of the year due to work. She is an ICU nurse at CHN and they are very short staffed.
US today
uterus 9.52 x 3.98x5.42 cm
endometrium 0.74
RT and LT ovaries 6.98 / 2.77
NL appearing uterus and ovaries.
small CL RT ovary
small amount free fluid RT adnexa.

Past History (reviewed - no changes required): None
Past Surgical History (reviewed - no changes required): Colonoscopy 2010 WNL

Last HPV: NOT DETECTED (09/01/2011 1:38:00 PM)

Pregnancy History
Total Preg.: 4
Full Term: 4
Premature: 0
Ab. Induced: 0
Ab. Spontaneous: 0
Ectopics: 0
Multiple Births: 0
Living: 4

Pregnancy #1



Clearvista Women's Care
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Lisa Shaurette
Female DOB:

Home:
Ins: Prohealt (433) Grp: CHM001

Breast inspection: no asymmetry, skin changes, or nipple discharge
Breast palpation: No masses or tenderness

Axillae: Normal

Genitourinary
Vulva: normal, no lesions or discharge
Urethral meatus: normal size and location, no lesions or discharge
Urethra: no discharge
Bladder: non tender
Vagina: loss of lateral vaginal wall support, with her bladder full second degree cystocele. small rectocele
Cervix: normal appearance, no lesions, no discharge
Uterus: normal size, mobile, nontender
Adnexa: no masses or tenderness
Anus and perineum: no condyloma or other lesions
Rectal exam: no masses or tenderness
iFOBT sent

Assessment/Plan
44 yo female with deep dyspareunia, pelvic pain and pressure at her vaginal opening. Pt. is desirous of an abdominal approach and woudl not entertain the idea of pellviscopic or Davinci surgery. We disc. the following procedures at length and the risks asc. with them. the option of tx. with pessary was offered and turned down by the pt.
The risks of surgery were reviewed today including the risk of bleeding, need for blood transfusion, HIV, HBV,transfusion reaction,infection,damage to the bowel,bladder,ureter,nerve,anesthesia complications/death.
She is scdheduled for TAH,BSO,Cullen Richardson Para Vaginal Repair, Suprapubic catheter,Cystoscopy.
Vaginal atrophy and dryness and the changes in libido and risks of osteoporosis without estrogen was disc.
She was givenACOG literature on pelvic support defects, hysterectomy, urinary incontinece, WHI Estrogen only info,preop and post op instructions.

Patient Counseled About:
Exercise
Bone Health/osteoporosis prevention
Pt. verbalizes understanding to treatment plan

LABS:
iFOBT: sent
Problems:
SCREENING FOR MALIGNANT NEOPLASM OF THE RECTUM (ICD-V76.41)
HOT FLASHES (ICD-627.2)
OLIGOMENORRHEA (ICD-626.1)
DYSPAREUNIA (ICD-625.0)

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Lisa Shaurette
Female DOB:

Ins: Prohealt (433) Grp: CHM001

Urethral meatus: normal size and location, no lesions or discharge
Urethra: no discharge
Bladder: non tender
Vagina: normal appearance, no discharge, lesions. No evidence of cystocele or rectocele.
Cervix: normal appearance, no lesions, no discharge
Uterus: normal size, mobile, nontender
Adnexa: Left adnexa/ovary WNL. Right ovary enlarged approx 4cms, nontender
Anus and perineum: no condyloma or other lesions
Rectal exam: no masses or tenderness
Pap Obtained
HPV: Obtained

Assessment/Plan

New Problems:
SCREENING FOR MALIGNANT NEOPLASM OF THE RECTUM (ICD-V76.41)
HOT FLASHES (ICD-627.2)
OLIGOMENORRHEA (ICD-626.1)
DYSPAREUNIA (ICD-625.0)
BREAST MASS, LEFT (ICD-611.72)
ROUTINE GYNECOLOGICAL EXAMINATION (ICD-V72.31)

1. Left breast mass. plan dx imaging and consult with breast MD.
2. Oligomenorrhea, hot flashes. Perimenopause discussed. Plan labs today, then keep menstrual calendar & call if periods not q3mos. Call if intermenstrual bleeding, if heavy or prolonged flow.
3. Chronic Pelvic Pain & Dyspareunia. Also right ovary ?cyst palpated today. Recommend pelvic US, then OV with Dr Box to consider laparoscopy (as previously discussed)

Patient Counseled About:

Weight Management
Exercise
Other: kegels
New Orders:
TSH [CPT-84443]
Free T-4 [CPT-84439]
Prolactin [CPT-84146]
Estradiol [CPT-82670]
FSH [CPT-83001]
Mammogram diagnostic [CPT-77051,77056]
Pap Image Assist Thin Prep and High Risk HPV [MACL#51181]
FIT-CHEK [CPT-82274]

Followup: US/OV with KB
Pt. verbalizes understanding to treatment plan
Patient instructed to call if symptoms persist or worsen

Pt Identifiers: NAME, DOB

DATE: 3-25-10 AGE:

HT: 52.50" WT: 128 BP: 114/60 T:

Lisa Sharrette
9166 Pointe Court
Fishers, IN 46037 / RN Nights IN ICU

ACCT: V323839C

SMOKER: Y (N) MARITAL STATUS:

No Family HX

G 4 P 4 Ab_Sp Ø Ab_TH Ø Ec Ø L 4 *Partner Vasectomy

CC: NP referral from (Melinda Smith) NP @ Fisher's Fam Med; AE, menopause sx's, (pelvic pain RT)

HPI: 1-3 (01,02,12,13); 4+ (03,04,05,14,15) Thyroid tests, ✓ U/s ₹ mo ago (NL). Tenderness & pain on RT side, Dyspareunia. LH ✓ FSH were [illegible] 5D Progesterone 10mg Medroxy years. Some Hot flashes & Night sweats was daily, *Has had Kidney Stones 6 mos ago

ROS: 1 system (13,02); 2-9(14,03); 10 (15,04,05) Has gained 10-15 #'s Abdominal

Allergies: NKA

Meds/Supplements: NONE

2/17/2010 U.S pelvis
- RF uterus 8.4 × 4.2 × 5.
- RT ovary 2.8 × 1.7 × 1.4
- LT ovary 2.9 × 1.6 × 1.9
- Small follicles bilat o/[illegible]
(NL)

Labs 2/2/2010 HCG ⊖, Prlc. FSH = 9.0.

LMP 3/[illegible]/10 unknown Cycle 25 q days Duration 6 Heavy (Mod) Light Dysmen. - +

Sexually Active + - (Male) Female Both Contraception: Vas Menopause @ 42 years old

Genitourinary complaints: No Bladder issues
BM's 4/day Ø diarrhea

Hot flushes - (+)
PMDD (-) +

Constit.	(-)	+	Resp.	(-)	+
HEENT	(-)	+	GI	(-)	+
Neuro	(-)	+	Heme	(-)	+
Psych	(-)	+	Endo	(-)	+
M.S.	(-)	+	Skin	(-)	+
CV	(-)	+	Breast Mass	(-)	+

Date of Last:

Pap	5/09
MMGM	Never
Cholesterol	10/09
Colorectal	Never
DEXA	Never

Genitourinary Examination: 1-5(12,01);6-11(13,02);12-18(14,03),19(15,04,05)

Urine Dipstick: P TR L TR B N N N

System	Normals:	Abnormal Description:
Constitutional	☐ WDF,NAD	
Neck (1)	☐ Supple; No TMG	
Resp (1)	☐ CTA-bilaterally	
CV (1)	☐ Regular rate	
	☐ No MGR	
	☐ No edema	
	☐ No varicosities	
GI (4)	☐ No HSM	
	☐ No Hernia	
	☐ No Masses	Hemoccult (-) +
Skin (1)	☐ No rash/scars	
	☐ No suspicious lesions	
Lymph (1)	No adenopathy (circle 2 of 3) Neck Axilla Groin	
Neuro/Psych	☐ Oriented x 3	
	☐ No Depression	

Genitourinary System (7)

Breasts:	(-)	+
Ext. Genit.	(-)	+
Urethra	(-)	+
Bladder	(-)	+
Vagina	(-)	+ *Thickened uterosacral lig. Post
Cervix	(-)	+
Uterus	NS/NS weeks	Ant Mid Post
Prior:	TAH TVH	BSO RSO LSO
Adnexa	(-)	+
Rectal	(-)	+
Perineum	(-)	+

Wet Mount: N/A

UPT: N/A

Tests Ordered:

(Pap)	MMGM	Ultrasound	FSH	E2	GC/CT
GHP	Fasting Lipid	DEXA	HCG	Other Tests Ordered:	

Preventative Counseling:

Folate	(Calcium)	Smoking Cessation	STDs	Safe Sex	BSE	Contraception
HRT	(Exercise Diet)	(Colonoscopy)	(Mammography)	Preconceptual Counseling		

Assessment/Plan: (including F/U) - Mammogram
- Colonoscopy, [illegible] → Hx of Kidney Stones 2 yo ago CT Scan w/ & w/out Contrast
- Consider Laparoscopy

cc: [illegible] NP @ Fishers Family Medicine

Meds Prescribed:
- Aygestin 5mg × 10d

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Lisa Shaurette
Female DOB:

Ins: Prohealt (433) Grp: CHM001

10/12/2011 - GYN Office Visit: Pelvic Exam & Discuss Surgery, CMG 1st
Provider: Kristina Box, MD
Location of Care: Clearvista Women's Care

PCP: Dr David Tetrick
HPI: Pelvic pain,dysmenorrhea, deep dyspareunia, mixed urinary incontinence.
Lisa is tired of being in pain all month. Her pain is crampy, suprapubic pressure. Intercourse causes stabbing pain so she avoids having sex. This is causing some marital problems.
Menses are every 21 -25 days apart,lasitng 6 days. She has one day of spotting before her period. Cramping for 2 days, 800 mg Ibuprofen bid takes the edge off.
BMs are very painful during her menses. Constipation has become a problem. Normal colonoscopy with Dr Carlson.
Symptoms of mixed urinary incontinence. She wears a panty liner most days. She does not feel like she empties out when she voids. She has had two hospitalizations for pyeolnephritis. She does have a history of renal stones.
Recent labs show an elevated TSH=5.76 FT4=1.3 FSH=7.6 E2=47.1 Prolactin=18.6. She has recently started Synthroid.
Cycles are very irregular
Urodynamic studies today show Void=47ml PVR<10ml VLPP=58-85(ISD) UCP= 32-37. Leakage at low volume of water
Past History (reviewed - no changes required): None
Past Surgical History (reviewed - no changes required): Colonoscopy 2010 WNL

Last HPV: NOT DETECTED (09/01/2011 1:38:00 PM)

Pregnancy History

Total Preg.: 4
Full Term: 4
Premature: 0
Ab. Induced: 0
Ab. Spontaneous: 0
Ectopics: 0
Multiple Births: 0
Living: 4

Pregnancy #1

ry: 38.5 weeks
s

Preterm labor: no
Comments/Complications: None

Pregnancy #2

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Lisa Shaurette
Female DOB:

Home: (
Ins: Prohealt (433) Grp: CHM001

38.4 weeks

Preterm labor: no
Comments/Complications: Posterior birth

Pregnancy #3

eks

Preterm labor: no
Comments/Complications: Posterior birth

Pregnancy #4

! weeks

Preterm labor: yes
Comments/Complications: Preterm

Current Problems

SCREENING FOR MALIGNANT NEOPLASM OF THE RECTUM (ICD-V76.41)
HOT FLASHES (ICD-627.2)
OLIGOMENORRHEA (ICD-626.1)
DYSPAREUNIA (ICD-625.0)
BREAST MASS, LEFT (ICD-611.72)

Social History:

Risk Factors

HIV and Drug Use Information
HIV high risk behavior: no

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Lisa Shaurette
Female DOB: [redacted]

Ins: Prohealt (433) Grp: CHM001

Review of Systems:
Genitourinary: Dyspareunia

PCP: Dr David Tetrick

Physical Exam
Appearance: well developed, well nourished, no acute distress

NECK
Neck: supple, no masses, trachea midline
Thyroid: no nodules, masses, tenderness, or enlargement

Respiratory
Respiratory effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Periph. circulation: no cyanosis, clubbing, edema, or varicosities

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal
Liver and spleen: no enlargement or nodularity
Hernia: No hernias

Musculoskeletal
Spine, ribs, pelvis: normal alignment and mobility, no deformity
Extremities: normal alignment, no joint enlargement, crepitus, masses or tenderness; normal tone and strength

Lymphatic
Nodes: no cervical, axillary, or inguinal adenopathy

Skin
Inspection/palpation: no ulcers, xanthomas

Mental Status Exam
Orientation: oriented to time, place, and person
Mood and affect: no depression, anxiety, or agitation

Breasts & Axilla:

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Lisa Shaurette
Female DOB: [redacted] Ins: Prohealt (433) Grp: CHM001

11/08/2011 - GYN Office Visit: pessary fitting
Provider: Cathy Hansell, NP
Location of Care: Clearvista Women's Care

PCP: Dr David Tetrick
HPI: Lisa has surgery scheduled with KB (total hyst with cystocele repair) on 12/12//2011.
Work in ICU, felt abd pressure in the last week, much cramping. On Saturday lifted a heavy patient and thought something almost popped, very uncomfortable. Is on lift restriction now, given note earlier today.

Here to try pessary to obtain some relief from pressure until she has surgery.

Past History (reviewed - no changes required): Hypothyroidism - diagnosed in 9/11
Last physical - 2009
Blood sugar has been borderline in the past
Past Surgical History (reviewed - no changes required): Colonoscopy 2010 WNL

Last HPV: NOT DETECTED (09/01/2011 1:38:00 PM)

Pregnancy History

Total Preg.: 4
Full Term: 4
Premature: 0
Ab. Induced: 0
Ab. Spontaneous: 0
Ectopics: 0
Multiple Births: 0
Living: 4

Pregnancy #1

.5 weeks

Preterm labor: no
Comments/Complications: None

Pregnancy #2

eks

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Lisa Shaurette
Female

Home:
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Preterm labor: no
Comments/Complications: Posterior birth

Pregnancy #3

weeks

Preterm labor: no
Comments/Complications: Posterior birth

Pregnancy #4

.2 weeks

Preterm labor: yes
Comments/Complications: Preterm

Current Problems

HYPERGLYCEMIA, BORDERLINE (ICD-790.29)
HYPOTHYROIDISM (ICD-244.9)
SCREENING FOR MALIGNANT NEOPLASM OF THE RECTUM (ICD-V76.41)
HOT FLASHES (ICD-627.2)
OLIGOMENORRHEA (ICD-626.1)
DYSPAREUNIA (ICD-625.0)
BREAST MASS, LEFT (ICD-611.72)

Current Medications

LEVOTHROID 75 MCG TABS (LEVOTHYROXINE SODIUM) Take one po daily on an empty stomach
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) one po qhs prn insomnia

Risk Factors

Family History (reviewed - no changes required): Adopted
She is part native american - worries about diabetes

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Lisa Shaurette
Female

[redacted]-4360
Ins: Prohealt (433) Grp: CHM001

Review of Systems:
General: Negative
Eyes: Negative
Ears/Nose/Throat: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Genitourinary Comments: pressure and prolapse/cramping
Musculoskeletal: Negative
Skin: Negative
Breast: Negative
Neurologic: Negative
Psychiatric: Negative
Endocrine: Negative
Heme/Lymphatic: Negative
Allergic/Immunologic: Negative

PCP: Dr David Tetrick
Height: 62
Current Weight: 135 pounds
Blood Pressure: 114/72 mm Hg
Body Mass Index: 24.78

Vitals signed by: Samantha Gorton, MA

Physical Exam
Appearance: well developed, well nourished, no acute distress

Gastrointestinal

Musculoskeletal

Mental Status Exam
Orientation: oriented to time, place, and person
Mood and affect: no depression, anxiety, or agitation

Genitourinary
Vulva: normal, no lesions or discharge
Urethral meatus: normal size and location, no lesions or discharge

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Lisa Shaurette
Female DOB

360
ns: Prohealt (433) Grp: CHM001

Urethra: no discharge
Bladder: non tender
Vagina: cystocele, 2nd degree
Cervix: normal appearance, no lesions, no discharge
Uterus: normal size, mobile, nontender
Adnexa: no masses or tenderness

Assessment/Plan

Status of Existing Problems:
Assessed CYSTOCELE WITHOUT MENTION UTERINE PROLAPSE MIDLN as unchanged - Cathy Hansell, NP
New Problems:
CYSTOCELE WITHOUT MENTION UTERINE PROLAPSE MIDLN (ICD-618.01)

Fitted with pessary/demonstrated removal and insertion.She is able to remove it only.
Ring with support with knob pessary , size 4 fitted. Patient is able to insert it , not remove it. She will have husband remove it , if he is unable, she will return to our office. Sent home with the pessary, discussed cleaning and care. Remove prior to intercourse.
Plans to use pessary until surgery. She says pessary did improve her discomfort.

Followup: has surgery planned
Pt. verbalizes understanding to treatment plan
Patient instructed to call if symptoms persist or worsen

Signed by Cathy Hansell, NP on 11/08/2011 at 5:32 PM
Signed by Cathy Hansell, NP on 11/09/2011 at 5:07 PM
Signed by Kristina Box, MD on 11/11/2011 at 9:01 AM

Community
Health Network

Community Hospital East
1500 North Ritter Avenue
Indianapolis, Indiana 46219-3095
317-355-1411 (tel)
eCommunity.com

10 November, 2011

To Whom It May Concern:

Regarding: Ms. Lisa Shaurette Fallon

Due to an acute illness and impending major abdominal surgery requiring hospitalization, Ms. Shaurette is not in a condition, at this time, which would allow her to travel, nor to be deposed.

Respectfully,

Robert S. Joseph, RPh, MD, FCCP
Medical Director, Critical Care and Progressive Care
Site Director, Critical Care Medicine, Internal Medicine and Pulmonary Medicine